U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 02 November 2004

CASE NO.: 2003-BLA-6192

In the Matter of

EARL ELLIOTT,
Claimant

v.

BUFFALO MINING CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard Stayton, Esq.,
For the Claimant

Mary Rich Maloy, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on August 15, 2001, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The Claimant filed his first prior claim for benefits on June 4, 1973. (Director's Exhibit ("DX") 1). The claim was denied because the evidence failed to establish Mr. Elliott had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. (DX 1).

The Claimant filed his second prior claim for benefits on August 12, 1992. (DX 2). On February 1, 1993, the Department of Labor denied Mr. Elliott's claim because the evidence failed to establish that Mr. Elliott had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. Claimant did not appeal the Department of Labor findings. (DX 2).

The Claimant filed his third claim for benefits on July 13, 1994. (DX 3). The Department of Labor denied this claim by Mr. Elliott because the evidence failed to establish that Mr. Elliott had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. Claimant did not appeal this determination. (DX 3).

The claimant filed his current claim for benefits on August 15, 2001. (DX 5). On April 14, 2003, the claim was approved by the District Director because the evidence established the elements of entitlement that Mr. Elliott has coal workers' pneumoconiosis and is totally disabled due to pneumoconiosis. (DX 36). On April 17, 2003, the employer requested a hearing before an administrative law judge. (DX 37). On July 1, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on February 2, 2004.

On July 1, 2004, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel. [1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-17, Director's exhibits ("DX") 1-45, and Employer's exhibits ("EX") 1-3, 5, 7, 13, 15-17, 19, 21, 23, 25, and 26 were admitted into the record. [2]

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[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(*en banc*), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, *i.e.*, here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] Employer's exhibits 2a, 4, 5a, 6, 8, 9, 10, 12, 14, 18, 20, 22 and 24 were not admitted due to exceeding the evidentiary limitations of 20 C.F.R. § 725.414. Employer's exhibit 11, a CT scan interpretation by Dr. Meyer, was excluded at the hearing. Employer asserts, in their closing argument, "[t]he limitation on CT scan evidence imposed by the Judge (excluding Employer's Exhibit 11) is likewise contrary to statute and governing case law, as well as without support by the regulations and contrary to *Dempsey v. Sewell Coal Co*., __ BLR__, BRB No. 03-0615-BLA (June 28, 2004)." The exclusion of Employer's exhibit 11 was based on cumulative evidence, not the evidence limitations found in 20 C.F.R. § 725.414. (TR 33). As such, the exclusion of Employer's Exhibit 11 stands. The following portions of Employer's exhibits 13 and 15 were also excluded at the hearing, based on cumulative evidence: (1) Dr. Wiot's reading of the December 12, 2001 CT scan; and (2) Dr. Shipley's reading of the December 12, 2001 CT scan. (TR 44).

The Employer submitted the following evidence post-hearing:

i. Deposition of Dr. Robert J. Crisalli, dated August 2, 2004; and
ii. Deposition of Dr. George L. Zaldivar, dated August 16, 2004.

These exhibits are hereby admitted into the record and marked as Employer's Exhibits EX 25 and 26, respectively.

Claimant's Counsel and Employer's Counsel submitted closing arguments post-hearing.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 12 years, as stipulated to by the parties. (Hearing Transcript (TR) 11; DX 6, 7).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on August 15, 2001. (DX 5). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[3]

Buffalo Mining Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G, Part 725 of the Regulations. [4] (TR 14).

D. Dependents

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife Mary Etta Kinney. (DX 9).

E. Personal, Employment and Smoking History[5]

The claimant was born on February 12, 1931. (DX 5). He married Mary Etta Kinney on September 10, 1966. Mr. Elliott and his wife currently live in the same household and remain married. (DX 9). Mr. Elliott's prior marriage ended in divorce. He provides no financial support to his previous wife. (DX 5). Claimant completed seventh grade and has no vocational training. (TR 13).

The Claimant began working in the coal mines in the 1950's. (DX 6). Mr. Elliott ceased working in the mines in 1992. The Claimant's last position in the coal mines was as an underground working foreman. Mr. Elliott had to run the equipment, shovel beltlines and rock dust, and fill vacant positions when necessary. Claimant testified that he had to lift 80-90 pounds as part of his regular job. (TR 15).

There is evidence of record that the claimant's respiratory disability may be due, in part, to his history of cigarette smoking. The Claimant testified that he began smoking at the age of 20. He stated that he smoked less than one pack of cigarettes per day. He stopped smoking in 1992. The Claimant consistently communicated this smoking history to examining doctors and testified to such at his July 1, 2004 hearing. (TR 17). Drs. Crisalli and Zaldivar explain that based the results of a carboxyhemoglobin test, Mr. Elliott must have either smoked immediately

[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

[4] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator" are defined in 20 C.F.R. §§ 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut the first, the employer must establish that there were no significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.,* 2 B.L.R. 1-1005 (1980). Neither, presumption has been rebutted in this case.

[5] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

before his examination with Dr. Crisalli, on July 1, 2002, or had been exposed to cigarette smoke immediately beforehand. (EX 25, 26). I find that Claimant smoked for at least forty years, based on his testimony and the smoking history he reported to the various doctors during examinations.

II. Medical Evidence[6]

The following is a summary of the medical evidence submitted in both his prior and most recent claims.

A. Chest X-rays[7]

As part of the current claim, there were 16 readings of 6 X-rays, taken on October 23, 2001, December 12, 2001, January 30, 2002, March 27, 2003, July 1, 2002, and April 10, 2004. [8] (DX 17, 18, 19, 20; EX 2, 3, 5, 21; CX 2, 3, 4, 5, 6, 7). Eight are positive, by four physicians, Drs. Baker, Miller, Ranavaya and Willis, all of whom are either B-readers, Board-certified in radiology, or both .[9] Seven are negative, by six physicians, Drs. Dameron, Scott, Spitz, Wheeler, Wiot and Zaldivar, all of whom are either B-readers, Board-certified in radiology, or both. Dr. Binns submitted a quality-only reading of the October 23, 2001 X-ray.

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 21	4/10/2004 5/26/2004	Dr. Scott	B, BCR	2 light		Apical nodular infiltrates or fibrosis, compatible with TB, unknown activity. Anterior chest surgery: CABG.
CX 3	4/10/2004 5/12/2004	Dr. Miller	B, BCR	1	1/2	Findings consistent with pneumoconiosis, category q/t, profusion ½. Bilateral apical scarring

[6] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[7] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[8] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[9] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						probably represents old tuberculosis rather than complicated pneumoconiosis. COPD (em).
CX 2	4/10/2004 4/10/2004	Dr. Baker	B, BCI/P	1	1/0	q/t. all zones.
CX 4	7/1/2002 4/9/2004	Dr. Miller	B, BCR	1	½	Findings consistent with pneumoconiosis, category t/s, profusion ½. Elevation of left hilum. Thickening of minor fissure. COPD. Coalescence of small pneumoconiotic opacities.
EX 5	7/1/2002 7/22/2002	Dr. Wheeler	B, BCR	1		Minimal fibrosis more likely than interstitial infiltrate both apices and subapical upper lobes compatible with healed TB or radiation therapy. Emphysema with areas of decreased and distorted lung markings. Few tiny calcified granulomata.
CX 5	3/27/2002 4/9/2004	Dr. Miller	B, BCR	2 over exposed	1/1	Findings consistent with pneumoconiosis, category t/s, profusion 1/1. COPD (em).
EX 3	3/27/2002 7/29/2003	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. The lung fields are over-expanded consistent with emphysema. Changes consistent with old granulomatous disease.
DX 20	3/27/2002 3/28/2002	Dr. Willis	B, BCR	1	1/1	There are parenchymal opacities predominantly in the upper lobes with much less numerous

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						reticulonodular parenchymal opacities in the mid and lower lung zones.
CX 6	1/30/2002 6/12/2003	Dr. Miller	B, BCR	1	1/1	Findings consistent with pneumoconiosis, category t/q, profusion 1/1. COPD (em).
EX 5	1/30/2002 5/31/2002	Dr. Spitz	B, BCR	1		No evidence of coal workers' pneumoconiosis. Previous CABG. Emphysema. Apical disease probably representing granulomatous disease, activity undetermined from this single study.
DX 12	1/30/2002 3/24/2002	Dr. Zaldivar	B, BCI/P	1		Em.
DX 19	12/12/2001 12/13/2001	Dr. Dameron	BCR			No definite evidence for actue cardiopulmonary process. Bilateral apical nodular densities which are probably underlying occupational lung disease.
CX 7	10/23/2001 5/12/2004	Dr. Miller	B, BCR	1	1/1	Findings consistent with pneumoconiosis, category p/s, profusion 1/1. bilateral apical scarring probably represents old tuberculosis rather than complicated pneumoconiosis. COPD (em).
EX 2	10/23/2001 12/16/2002	Dr. Wiot	B, BCR	1		No evidence of coal workers' pneumoconiosis. There is old granulomatous disease present at both apices. The lung fields

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
						are over-expanded, consistent with emphysema.
DX 18	10/23/2001 1/22/2002	Dr. Binns	B, BCR	1		Quality only reading.
DX 17	10/23/2001 10/23/2001	Dr. Ranavaya	B	1	1/1	

Chest X-rays from Prior Claims:

There were 16 readings of five X-rays. Five of the readings were positive for pneumoconiosis and eleven readings were negative. (DX 1, 2, 3).

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 3	4/28/1995 8/12/1995	Dr. Francke	B, BCR	2	0/1	
DX 3	4/28/1995 7/26/1995	Dr. Francke	B, BCR	1	0/1	
DX 3	4/28/1995 6/8/1995	Dr. Shipley	B, BCR	1		Film is completely negative.
DX 3	4/28/1995 5/31/1995	Dr. Spitz	B, BCR	1		Film is completely negative.
DX 3	4/28/1995 5/19/1995	Dr. Wiot	B, BCR	2		Film is completely negative.
DX 3	4/28/1995 4/28/1995	Dr. Bassali	B, BCR[10]	2	1/1	
DX 3	8/17/1994 10/7/1994	Dr. Gaziano	B	1	0/1	
DX 3	8/17/1994 9/28/1994	Dr. Sargent	B, BCR	1		No abnormalities consistent with pneumoconiosis. Em.
DX 3	8/17/1994 8/17/1994	Dr. Ranavaya	B	1	1/0	
DX 2	10/10/1992 1/9/1993	Dr. Francke	B, BCR	1		No abnormalities consistent with pneumoconiosis. Em.
DX 2	10/10/1992	Dr.	B, BCR	1		No abnormalities

[10] Dr. Bassali's qualifications are noted in Dr. Rasmussen's written report. (DX 3).

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
	12/22/1992	Sargent				consistent with pneumoconiosis. Em.
DX 2	10/10/1992 10/10/1992	Dr. Ranavaya	B	1	1/0	
DX 1	8/3/1980 10/12/1980	Dr. Sargent	B, BCR	2	0/0	
DX 1	8/3/1980 8/3/1980	Dr. Deardorff	BCR	1	1/2 2/2	1/2 – small rounded opacities. 2/2 – small irregular opacities.
DX 1	7/19/1973 9/28/1973	Dr. Strong				Completely negative.
DX 1	7/19/1973 7/19/1973	Dr. Pelaez			1/0	Pneumoconiosis. Pulmonary emphysema.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

CT Scans

The record contains the results of three CT scans read by various physicians. A CAT scan falls into the "other medical evidence" submitted under 20 C.F.R. § 718.107 (2001). Under the 20 C.F.R. § 725.414 evidentiary limitations, there are no numerical limits on "other medical evidence." Thus, revised 725.414 imposes no numerical limit on CT scan readings submitted as a party's affirmative case. *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). A CAT scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)." *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). In *Consolidation Coal C. v. Director, OWCP [Stein]*, ___ F.3d ___, 22 B.L.R. 2-409,

2002 WL 1363785 (7th Cir. June 25, 2002), the Court rejected the employer's argument that a negative CT is conclusive evidence the miner does not have pneumoconiosis. The DOL has rejected such a view. Nor need a negative CT be given controlling weight because the statutory definition of "pneumoconiosis" encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical test such as X-rays and CT scans.

September 21, 2003 CT Scan:

Dr. Miller, a B-reader and Board-certified radiologist, submitted an interpretation of the Claimant's CT scan. (CX 8). Dr. Miller observed findings compatible with complicated coal workers' pneumoconiosis, category A and chronic obstructive pulmonary disease. In the left lung apex, Dr. Miller found an irregular 3 X 1.5 cm density. In the right lung apex, Dr. Miller found a 2 cm irregular density. He noted that the location, appearance, relative symmetry and size are consistent with conglomerate masses of complicated coal workers' pneumoconiosis. Dr. Miller adds a comment to his impression: "While the appearance of the lung apices is compatible with complicated coal workers' pneumoconiosis, scarring from previous granulomatous infection such as tuberculosis is also a consideration." (CX 8).

Dr. Cappiello, a B-reader and Board-certified radiologist, also interpreted the September 21, 2003 CT Scan. Dr. Cappiello found increasing fibrosis in the apices of both lungs. He also noted hyperinflation of lungs with small emphysematous lobular bullae scattered in both lungs. Dr. Cappiello stated "[t]here are scattered small nodules in both lungs which may represent small granulomas related to old granulomatous disease or small opacities of pneumoconiosis or a combination of the two." Dr. Cappiello also noted advanced changes of chronic obstructive pulmonary disease. (CX 9).

Dr. Wiot, a B-reader and Board-certified radiologist, reviewed the September 21, 2003 CT scan. Dr. Wiot found no evidence of coal workers' pneumoconiosis. Dr. Wiot did find extensive emphysema. He also found markings consistent with old granulomatous disease with residual scarring. (EX 13).

Dr. Shipley, a B-reader and Board-certified radiologist, concluded that there is no evidence of small or large rounded opacities that are consistent with coal workers' pneumoconiosis. He found moderate upper zone predominant emphysema. He noted evidence of a "fibrotic process in the apical portions of each upper lobe that is most consistent with infection such as tuberculosis or fungal disease." (EX 15).

July 13, 2002 CT Scan:

Dr. Miller submitted an interpretation of the July 13, 2002 CT scan. Dr. Miller noted evidence of moderately severe chronic obstructive pulmonary disease with hyperexpansion of the lungs and emphysematous change with multiple small bullae. He stated that the increased interstitial lung markings are compatible with a combination of chronic obstructive lung disease and pneumoconiosis. Dr. Miller stated that the bilateral apical scarring is suggestive of chronic scarring due to previous granulomatous infection such as tuberculosis. He noted, however, "[p]neumoconiosis may also be considered as an etiology for the apical abnormalities, although

there is often more interstitial profusion than is seen on the current CT scan when these types of apical abnormalities are secondary to conglomerate pneumoconiosis." (CX 10).

Dr. Cappiello interpreted the July 13, 2002 CT Scan. He noted considerable hyperinflation of the lungs with changes of underlying chronic obstructive pulmonary disease with scattered foci of lobular emphysema. Dr. Cappiello found scattered small nodules in both lungs. He stated that these may represent scattered small granulomas or small opacities of pneumoconiosis or a combination. Dr. Cappiello also noted advanced changes of COPD. (CX 11).

Dr. Wiot reviewed the July 13, 2002 CT scan. Dr. Wiot found no evidence of coal workers' pneumoconiosis. Dr. Wiot did find extensive emphysema. He also found markings consistent with old granulomatous disease with residual scarring. (EX 13).

Dr. Shipley concluded that there is no evidence of small or large rounded opacities that are consistent with coal workers' pneumoconiosis . He found moderate upper zone predominant emphysema. He noted evidence of a "fibrotic process in the apical portions of each upper lobe that is most consistent with infection such as tuberculosis or fungal disease." (EX 15).

December 12, 2001 CT Scan:

Dr. Dameron, a Board-certified radiologist, reviewed the December 12, 2001 CT scan. He concluded that findings within the chest are "highly suggestive of occupational lung disease with biapical predominance." Dr. Dameron also noted some atherosclerotic calcification of the aortic arch as well as coronary artery calcifications. (DX 19).

Dr. Miller found that the December 12, 2001 CT scan showed moderately severe chronic obstructive pulmonary disease with multiple small bullae. Dr. Miller noted increased interstitial markings. He explained that these are compatible with a combination of chronic obstructive pulmonary disease and pneumoconiosis. Dr. Miller found bilateral apical scarring composed of multiple, irregular, relatively symmetrical densities. He explained that these are most suggestive of chronic scarring due to previous granulomatous infection such as tuberculosis. But, he stated that pneumoconiosis may also be considered an etiology for the apical abnormalities. (CX 12).

Dr. Cappiello concluded that the December 12, 2001 CT scan demonstrates advanced changes of chronic obstructive pulmonary disease. Dr. Cappiello observed "scattered small nodular densities in both lungs which may represent scattered granulomas or may represent the small opacities of pneumoconiosis or a combination thereof." (CX 13).

Dr. Fishman, a B-reader and Board-certified radiologist, interpreted the December 12, 2001 CT scan. Dr. Fishman noted emphysematous changes. Dr. Fishman found no evidence of coal workers' pneumoconiosis or silicosis. He noted that the areas of fibrotic changes in the upper lung zones bilaterally is consistent with prior inflammatory disease such as tuberculosis. (EX 5; DX 22).

Dr. Wheeler, a B-reader and Board-certified radiologist, determined that the December 12, 2001 CT scan showed no evidence of pneumoconiosis. He noted minimal healed

TB with linear and irregular scars in the left apex. He also found minimal to moderate emphysema with areas of decreased and distorted lung markings. (DX 21).

CT Scans from Prior Claims

Dr. Wheeler, a B-reader and Board-certified radiologist, reviewed a May 12, 1994 CT scan of the Claimant. Dr. Wheeler found no evidence of coal workers' pneumoconiosis. Dr. Wheeler noted a few small apical scars which he contributes to healed tuberculosis. He also noted focal arteriosclerosis of coronary arteries. (DX 3).

Dr. Fishman also reviewed the May 12, 1994 CT scan. Dr. Fishman concluded that there is no evidence of pneumoconiosis. Dr. Fishman noted minimal calcification in the left coronary artery. He found scarring in the left lung zone consistent with prior inflammatory disease, possibly tuberculosis. (DX 3).

B. Pulmonary Function Studies[11]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Trac-ings**	**Comprehen-sion Cooperation**	**Qualify * Conform ****	**Dr.'s Impression**
Dr. Baker 4/10/2004 CX 2	73 70.25"	1.05		3.21	Yes	Good Fair	Yes[12] Yes	Severe obstructive ventilatory defect.
Dr. Crisalli 7/1/2002 EX 1	71 70"	1.24	47	3.08	Yes	Good Good	Yes Yes	Severe expiratory air flow obstruction. No restrictive defect. Moderate air trapping. Severe diffusion defect (hemoglobin corrected).
Dr. Crisalli	71	1.85		4.29	Yes	Good	Yes[13]	Significant

[11] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).
[12] The FEV1/FVC ratio equals 32.7%.

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Trac-ings	Comprehen-sion Cooperation	Qualify * Conform **	Dr.'s Impression
7/1/2002 EX 1 Post-Bron	70"					Good	Yes	post-bronchodilator improvement.
Dr. Zaldivar 1/30/2002 DX 12	70 71"	1.56	49	3.78	Yes		Yes Yes	Moderate irreversible obstruction. Normal lung volume. Moderate diffusion impairment.
Dr. Zaldivar 1/30/2002 DX 12 Post-Bron	70 71"	1.62	53	4.21	Yes		Yes Yes	
Dr. Ranavaya 10/23/2001 DX 14	70 71"	1.70		3.34	Yes	Good Good	Yes[14] Yes	
Dr. Ranavaya 10/23/2001 DX 14 Post-Bron	70 71"	1.51		2.88	Yes	Good Good	Yes[15] Yes	

Pulmonary Function Studies from Prior Claims

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Trac-ings	Comprehen-sion Cooperation	Qualify * Conform **	Dr.'s Impression
Dr. Zaldivar 4/28/1995 DX 3	64 70"	2.17	70	4.53	Yes	good	Yes[16] Yes	
Dr. Zaldivar 4/28/1995 DX 3 Post-bron	64 70"	2.21	85	4.65	Yes	good	Yes[17] Yes	
Dr.	64	2.13	87.17	4.11	Yes		Yes[18]	Moderate,

[13] The FEV1/FVC ratio equals 43.1%
[14] The FEV1/FVC ratio equals 50.9%.
[15] The FEV1/FVC ratio equals 52.4%.
[16] The FEV1/FVC ratio equals 47.9%.
[17] The FEV1/FVC ratio equals 47.5%.
[18] The FEV1/FVC ratio equals 51.8%.

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Trac-ings	Comprehen-sion Cooperation	Qualify * Conform **	Dr.'s Impression
Rasmussen 4/21/1995 DX 3	70.3"						Yes	irreversible obstructive ventilatory impairment.
Dr. Rasmussen 4/21/1995 DX 3 Post-bron	64 70.3"	2.26	92.5	4.43	Yes		Yes[19] Yes	
Dr. Ranavaya 9/29/1994[20] DX 3	63 72"	2.13	84.1	3.58	Yes	Good Good	Yes Yes	
Dr. Ranavaya 9/29/1994 DX 3 Post-bron	63 72"	2.16	98.6	3.62	Yes	Good Good	No Yes	
Dr. Ranavaya 8/17/1994[21] DX 3	63 72"	1.80	59.7	2.04	Yes	Fair Fair	Yes Yes	
Dr. Ranavaya 8/17/1994 DX 3 Post-Bron	63 72"	2.04	72.3	3.36	Yes	Fair Fair	Yes Yes	
Dr. Ranavaya 10/10/1992 DX 2	61 72"	2.39	69.5	3.97	Yes	Good Good	No Yes	
Dr. Ranavaya 10/10/1992 DX 2 Post-Bron	61 72"	2.42	60	4.01	Yes	Good Good	No Yes	
Dr. Fritzhand	49 72"	3.0	96		Yes	Good Good	No Yes	

[19] The FEV1/FVC ratio equals 51.0%.

[20] Dr. Gaziano reviewed the September 29, 1994 pulmonary function study. Dr. Gaziano determined that the vents are acceptable. (DX 3).

[21] Dr. Gaziano reviewed the August 17, 1994 pulmonary function study. Dr. Gaziano determined that the vents are not acceptable, due to less than optimal effort, cooperation and comprehension. (DX 3).

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Trac-ings	Comprehen-sion Cooperation	Qualify * Conform **	Dr.'s Impression
8/3/1980 DX 1								

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

Dr. Zaldivar reviewed the October 23, 2001 pulmonary function study. He noted that the plateau phase was not reacted after 7 ½ seconds of exhalation. He did, however, find the effort adequate and noted no hesitation in exhalation. Dr. Zaldivar concluded the study is valid. (DX 16). Dr. Gaziano, Board-certified in internal medicine and chest disease, also reviewed the October 23, 2001 pulmonary function study. Dr. Gaziano concluded that the vents are acceptable.

For a miner of the claimant's height of 71.06 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.98 for a male 71 years of age. [22] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.55 or an MVV equal to or less than 79; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
70	71	1.88	2.43	75
71	70	1.99	2.57	80
70	64	2.00	2.55	80

[22] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 71.06" here, his average reported height.

Height	Age	FEV_1	FVC	MVV
70.3	64	2.03	2.59	81
72	63	2.17	2.77	87
72	61	2.20	2.80	88
72	49	2.39	3.01	96

C. Arterial Blood Gas Studies[23]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
4/10/2004 CX 2	Dr. Baker	39	73	No	Exercise study not performed due to Claimant's ischemic heart disease.
7/1/2002 EX 1	Dr. Crisalli	40	76	No	An exercise study was not performed due to Claimant's history of coronary artery disease.
1/30/2002 DX 12	Dr. Zaldivar	33 34*	75 70*	No No	Exercise stopped due to dizziness. There is a drop in pO2 compatible with the low diffusion. Test is compatible with pulmonary fibrosis. Can't completely rule out emphysema as the cause of the drop in pO2.
10/23/2001 DX 13	Dr. Ranavaya	35 34.9*	71 70.6*	No No	

Arterial Blood Gas Studies from Prior Claims

[23] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
4/28/1995 DX 3	Dr. Zaldivar	32 32*	84 71*	No No	
4/21/1995 DX 3	Dr. Rasmussen	38 37*	73 66*	No No	
8/17/1994 DX 3	Dr. Ranavaya	38.2	70.9	No	
10/10/1992 DX 2	Dr. Ranavaya	38	77	No	
8/3/1980 DX 1	Dr. Fitzhand	39.6 41.0*	84.2 90.0*	No No	

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports [24]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Baker is a B-reader and is Board-certified in internal medicine and pulmonary disease. (CX 15). His examination report, based upon his examination of the claimant, on April 10, 2004, notes 43 years of coal mine employment. Dr. Baker noted that Claimant began smoking less than one pack of cigarettes per day at age 20 and stopped smoking at age 60. Dr. Baker listed Claimant's medical history as attacks of wheezing, chronic bronchitis, heart disease and a penicillin allergy. Dr. Baker described the claimant's symptoms as daily sputum, daily wheezing, dyspnea, daily cough, chest pain, and orthopnea. Dr. Baker also noted Claimant's current medications: lipitor 20 mg, Bextra, Proventil nebulizer treatments, Pulmicort Respules, Foradil Aerolzier, Xanax 0.5 mg, and Darvocet N-100. (CX 2).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Baker listed his diagnosis as:

[24] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

1. coal workers' pneumociosis;
2. COPD with severe obstructive defect;
3. chronic bronchitis;
4. hypoxemia; and
5. ischemic heart disease.

Dr. Baker noted that coal dust exposure caused his pneumoconiosis. He stated that coal dust exposure and cigarette smoking caused Claimant's COPD, chronic bronchitis and hypoxemia. (CX 2).

Dr. Baker found that Claimant has a severe pulmonary impairment. On a question form attached to his report, Dr. Baker checks that Claimant has a severe impairment and is totally disabled. He notes that Claimant does not have the respiratory capacity to perform his previous coal mine work. Dr. Baker attributes Claimant's pulmonary impairment to coal dust exposure and cigarette smoking. (CX 2).

Dr. Robert Crisalli is Board-certified in internal medicine and pulmonary disease. His report, dated October 10, 2002, based upon his examination of the claimant, on July 1, 2002, notes 43 years of coal mine employment and a 30 year smoking history at less than one pack of cigarettes per day. Dr. Crisalli described the claimant's symptoms as shortness of breath, dyspnea, and cough productive of sputum. Claimant informed Dr. Crisalli that he has to stop to catch his breath after climbing 10 to 12 stairs and has difficulty carrying weight any distance. Mr. Elliott complained to Dr. Crisalli of two pillow orthopnea for more than twenty years and paroxysmal nocturnal dyspnea for fifteen years. Dr. Crisalli noted Claimant's medications as Lipitor, Combivent inhaler, Serevent inhaler, and Flovent inhaler. (EX 1).

Dr. Crisalli noted that his examination of the chest and lungs presented no rales, wheezes or prolonged expiration. He noted breath sounds present and equal bilaterally. Based on his examination of Claimant and review of Claimant's medical records, Dr. Crisalli diagnosed chronic obstructive pulmonary disease with components of emphysema and chronic bronchitis. Dr. Crisalli concluded that there is no evidence of coal workers' pneumoconiosis. (EX 1).

Dr. Crisalli opined that Mr. Elliott has significant respiratory impairment which would prevent him from performing his previous job in the coal mines. Dr. Crisalli stated that Mr. Elliott's impairment is due to his significant emphysema which is caused by his heavy smoking history. He explained that none of Mr. Elliott's impairment is caused by coal dust exposure. (EX 1).

On August 2, 2004, Dr. Crisalli was deposed by Employer's counsel. Dr. Crisalli reiterated that he is Board-certified in internal medicine and pulmonary disease. (EX 25). Dr. Crisalli stated that he conducted a complete evaluation of Mr. Elliott in July of 2002. (EX 25, p.5). Dr. Crisalli noted that Claimant worked in the coal mines for 43 years. He stated that it is a sufficient exposure to cause coal workers' pneumoconiosis in a susceptible individual. He also noted that Claimant smoked less than one pack of cigarettes per day for 30 years, quitting in 1992. (EX 25, p.6).

Dr. Crisalli stated that Claimant has a history of coronary artery disease and complains of shortness of breath and productive cough. Dr. Crisalli stated that Claimant uses several inhalers for his pulmonary disease and takes cholesterol medication. Dr. Crisalli testified that it is his practice to avoid pulmonary stress tests in patients with a history of coronary artery disease. (EX 25, p.8). Dr. Crisalli performed a resting blood gas study. He concluded that the results were normal. He found, however, that the pulmonary function study showed a severe degree of obstruction to air flow while Claimant was exhaling. He explained that the pulmonary function study results are consistent with an obstructive lung disease. He stated that the lung volume study showed a moderate degree of air trapping, indicating the presence of emphysema. He noted that the pulmonary function study resulted in a severe diffusion defect. Dr. Crisalli explained "[T]he alveolar volume or VA value was higher than the ratio between the diffusion and the alveolar volume, which would be consistent with emphysema." (EX 25, p.9). Dr. Crisalli testified that Claimant's post-bronchodilator results revealed a "49% improvement in the Forced Expiratory Volume in one second." (EX 25, p.10).

Dr. Crisalli reviewed Dr. Baker's testing of the Claimant. He stated that Dr. Baker's results were consistent with a severe pulmonary impairment. He also stated that "Dr. Baker was hampered by not having a post-bronchodilator challenge." (EX 25, p.12). Dr. Crisalli testified regarding the pulmonary function study he performed, the one performed by Dr. Baker and various "older" pulmonary function studies of the Claimant. He stated:

> Taking all the pulmonary function studies together, I believe Mr. Elliott has primarily emphysema based on the obstruction to air flow and the significant degree of air trapping which is typical for emphysema. This type of air trapping is not seen in coal workers' pneumoconiosis but is very commonly seen in individuals who have lung disease secondary to their smoking habit, period.
>
> The other thing is that there was significant improvement after bronchodilators in my examination and this raises the issue of reactive airways disease or asthma.

(EX 25, p.13). Dr. Crisalli concluded that Mr. Elliott has a "totally impairing pulmonary impairment." He stated "I would have to conclude it would prevent him from doing his job with the proviso that if he had that intensive bronchodilator therapy, he may be able to do that job." (EX 25, p.14).

Dr. Wheeler reviewed the X-ray taken of Claimant during Dr. Crisalli's examination. Dr. Wheeler determined that there is no evidence of coal workers' pneumoconiosis. Dr. Crisalli testified that Dr. Wheeler's finding is consistent with his overall interpretation of the data. (EX 25, p.16).

Dr. Crisalli reviewed Dr. Kowalti's treatment records of the Claimant. Dr. Crisalli does not agree with Dr. Kowalti's finding of coal workers' pneumoconiosis. He agrees with Dr. Kowalti's diagnosis of asthma. (EX 25, p.18).

After reviewing the medical evidence, including various readings of X-rays and CT scans, Dr. Crisalli concluded that Mr. Elliott "has primarily emphysema related to his heavy smoking history and this has caused a significant degree of impairment." (EX 25, p.26). He also

noted that the reversibility found in Claimant's testing is evidence of asthma. Dr. Crisalli stated that none of Mr. Elliott's pulmonary impairment is related to coal dust exposure. Dr. Crisalli testified that there is no evidence of complicated pneumoconiosis. (EX 25, p.30).

Dr. Crisalli submitted a supplemental report, dated May 24, 2004. Dr. Crisalli reviewed his prior examination of the Claimant and Dr. Baker's report. Dr. Crisalli noted that Dr. Baker's report "consists of one sheet wherein he expresses his opinion." [25] Dr. Baker concluded that Claimant has coal workers' pneumoconiosis and is totally disabled due to pneumoconiosis. Dr. Crisalli disagrees with Dr. Baker's conclusion and states that there is "nothing in Dr. Baker's one page report to cause me to change my opinion." (EX 17).

Dr. Zaldivar is a B-reader and is Board-certified in internal medicine and pulmonary disease. His report, dated March 25, 2002, based upon his examination of the claimant, on January 30, 2002, notes 43 years of coal mine employment. He noted that Claimant began smoking less than a pack of cigarettes per day in his 20's and stopped in 1992. Dr. Zaldivar described the claimant's symptoms as shortness of breath, cough and wheezing. He noted that Claimant had coronary bypass surgery in July 2000. Dr. Zaldivar listed Claimant's medications as Lipitor, Bayer Aspirin, Combivent, Serevent, Flovent and Centrum Silver. (DX 12).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Zaldivar diagnosed emphysema. Dr. Zaldivar noted that the tests performed during his examination of the Claimant underestimate the degree of emphysema present. Dr. Zaldivar concluded that Mr. Elliott does not have coal workers' pneumoconiosis or any dust disease of the lungs. (DX 12).

Dr. Zaldivar opined that Claimant is totally disabled. He noted that Mr. Elliott's pulmonary impairment would prevent him from performing his previous coal mine employment. He stated that Claimant's pulmonary impairment is a result of his smoking habit. (DX 12).

On August 16, 2004, Dr. Zaldivar was deposed by Employer's counsel. Dr. Zaldivar reiterated that he is a B-reader and is Board-certified in internal medicine, pulmonary medicine, sleep disorders and intensive care medicine. (EX 26). Dr. Zaldivar stated that he examined Mr. Elliott on three occasions. [26] (EX 26, p.12). Dr. Zaldivar stated that Mr. Elliott worked in the coal mines for 43 years, which is a sufficient amount of time to cause a lung disease in a susceptible individual. He also stated that Mr. Elliott had a sufficient smoking history to cause a lung disease in a susceptible individual. (EX 26, pp.13-14).

Dr. Zaldivar found that Claimant has a moderate airway obstruction. Dr. Zaldivar stated that Claimant's airway obstruction did not improve with bronchodilators. (EX 26, p. 15). Dr. Zaldivar also noted a normal total lung capacity and a reduced diffusion capacity. Dr. Zaldivar

[25] Claimant's exhibit 2 consists of Dr. Baker's examination report. This report is numerous pages. The last page of Dr. Baker's report is a form consisting of four questions answered by Dr. Baker. It appears that Dr. Crisalli only received and reviewed the last page of Dr. Baker's report. Dr. Crisalli did not have any test results from Dr. Baker's examination of the Claimant. Dr. Crisalli stated "I only have Dr. Baker's answers to various questions posed to him."

[26] The record contains one examination by Dr. Zaldivar in the current claim and one examination in Claimant's third claim for benefits.

stated that the blood gas results were abnormal. He explained that the exercise blood gas study was stopped because the Claimant became dizzy. (EX 26, p.16). Dr. Zaldivar concluded that Claimant has a severe pulmonary impairment. Dr. Zaldivar does not attribute Claimant's impairment to coal workers' pneumoconiosis. He opined that claimant has smoker's emphysema, not coal workers' pneumoconiosis. (EX 26, p.17).

Dr. Zaldivar discussed X-ray interpretations by Dr. Spitz and Dr. Miller of an X-ray taken during Dr. Zaldivar's examination of the Claimant. Dr. Spitz did not find evidence of pneumoconiosis. Dr. Miller determined that pneumoconiosis is present with a profusion of 1/1. Dr. Zaldivar testified that he would rely on Dr. Spitz's interpretation because "Dr. Spitz has a longstanding reputation as a consistent reader of films for the ILO purposes." Dr. Zaldivar did not provide any reason to discredit Dr. Miller's interpretation. (EX 26, p. 20).

Dr. Zaldivar discussed the breathing tests Dr. Crisalli performed. He stated that Dr. Crisalli's results showed a severe impairment and were consistent with emphysema. (EX 26, p.24). Dr. Zaldivar explained why Dr. Crisalli's tests showed improvement after bronchodilators and his did not. Dr. Zaldivar stated that Mr. Elliott was not smoking or exposed to cigarette smoke when he was examined by Dr. Zaldivar on January 30, 2002. Dr. Crisalli's carboxyhemoglobin test results show that Mr. Elliott was either smoking again or in close contact with an individual smoking several hours before Dr. Crisalli's examination. Dr. Zaldivar explained that cigarette smoke produces inflammation of the airways with mucous production, which can be treated with bronchodilators. Dr. Zaldivar stated that Dr. Crisalli's results show that Claimant has an asthmatic component to his breathing problem which was stimulated again by cigarette smoke exposure. (EX 26, p.26).

Dr. Zaldivar reviewed Dr. Baker's examination of the Claimant. Dr. Baker did not perform a post-bronchodilator pulmonary function study. Dr. Zaldivar testified that Dr. Baker was limited in information because he did not perform a post-bronchodilator study. (EX 26, pp.30-31). Dr. Zaldivar discussed Dr. Baker's X-ray and CT scan taken during Claimant's examination. Dr. Baker interpreted the CT scan as showing nodules throughout both lungs. Drs. Scatarige and Scott interpreted the CT scan and X-ray as showing a few nodules in the apex only. [27] Dr. Zaldivar stated that this is a "big difference" in interpretation. (EX 26, p. 34).

Dr. Zaldivar testified that Mr. Elliott's emphysema and asthma are not caused by coal dust exposure. (EX 26, p.27). He stated that Mr. Elliott's lungs are damaged from cigarette smoking. (EX 26, p. 36). Dr. Zaldivar testified that there is no evidence of complicated pneumoconiosis. (EX 26, p.39). Dr. Zaldivar stated that he cannot conclude whether the abnormalities are a result of tuberculosis exposure without a biopsy. (EX 26, p.40).

Dr. Ranavaya, a B-reader, performed the Department of Labor examination. His report, based upon his examination of the claimant, on October 23, 2001, notes 40 years of coal mine employment. He noted that Claimant began smoking a ½ pack of cigarettes per day at age 18 and stopped smoking in 1992. Dr. Ranavaya noted that Claimant had prostate surgery and open heart surgery. Dr. Ranavaya described the claimant's symptoms as daily sputum, nightly wheezing, daily dyspnea, daily cough, occasional chest pain, orthopnea and occasional

[27] The interpretation by Dr. Scatarige is not part of the record and is not considered in determining pneumoconiosis.

paroxysmal nocturnal dyspnea. He noted that Mr. Elliott complains of shortness of breath upon mild to moderate exertion. Claimant becomes short of breath walking about 50 feet on level ground, about 10-15 feet up a gentle incline and up about 6-8 steps. Dr. Ranavaya noted Claimant's medications as Lipitor, Centrum Silver, Serevent, Ascriptin, Flovent and Combivent. (DX 11).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed pneumoconiosis and coronary artery disease. He noted that Claimant's pneumoconiosis is caused by occupational exposure to coal dust. Dr. Ranavaya concluded that Claimant has a moderate pulmonary impairment, caused by his pneumoconiosis, which would prevent him from performing his last coal mine employment. (DX 11).

Physicians' Reports from Prior Claims

Dr. Zaldivar submitted a report, dated May 8, 1995, based upon his examination of the Claimant, on April 23, 1995. (DX 3). He noted that Claimant had 43 years of coal mine employment. Dr. Zaldivar noted that Claimant began smoking in his 20's, at half a pack per day, and quit in 1993. He listed Claimant's chief complaint as shortness of breath. He also noted wheezing and cough productive of sputum. Dr. Zaldivar noted that Claimant sleeps on two pillows because of his shortness of breath. (DX 3).

Based on his examination of the Claimant and his review of the Claimant's medical records, Dr. Zaldivar concluded "there is no evidence in this case to justify a diagnosis of coal workers' pneumoconiosis nor any pulmonary impairment caused by nor aggravated by coal mine work." Dr. Zaldivar determined that Mr. Elliott suffers from emphysema. (DX 3).

Dr. Zaldivar found that Mr. Elliott has a pulmonary impairment that would prevent him from performing very heavy manual labor. He concluded that Mr. Elliott would be able to perform supervisory work, but not very heavy manual labor. (DX 3).

Dr. Rasmussen examined the Claimant on April 21, 1995. (DX 3). Dr. Rasmussen noted Mr. Elliot's complaints as shortness of breath, dyspneic after climbing a flight of stairs, minimal productive morning cough, wheezing, and anterior chest tightness. Dr. Rasmussen noted that Claimant worked in the coal mines for 43 years and smoked ½ a pack of cigarettes per day from 1949 until 1993. (DX 3).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. He also concluded that Claimant's respiratory impairment would prevent him from performing his previous coal mine employment with its requirement for heavy manual labor. Dr. Rasmussen opined that Claimant's smoking and pneumoconiosis caused his respiratory impairment. He stated that the pneumoconiosis "must be considered at least a major contributing factor." Dr. Rasmussen noted that Claimant's respiratory impairment is evidenced by the reduced ventilatory capacity, the abnormal diffusing capacity, increased dead space ventilation, and impairment in oxygen transfer during exercise. (DX 3).

Dr. Zaldviar submitted a supplemental report, dated May 18, 1995, based on his review of Dr. Rasmussen's report. Dr. Zaldivar disagrees with Dr. Rasmussen's diagnosis of coal

workers' pneumoconiosis. Dr. Zaldivar explained that Mr. Elliott's chest X-ray shows flattening of the diaphragms and bullae in the lungs compatible with emphysema. He also noted that Claimant's low diffusion capacity and moderate airway obstruction is compatible with emphysema. (DX 3).

Dr. Ranavaya examined the Claimant on August 17, 1994. (DX 3). Dr. Ranavaya noted 43 years of coal mine employment. Dr. Ranavaya noted that the Claimant began smoking 1/2 to 1 pack of cigarettes per day in 1951 and stopped smoking in 1994. He listed Claimant's symptoms as sputum, wheezing, dyspnea, cough, chest pain, orthopnea and paroxysmal nocturnal dyspnea. (DX 3).

Dr. Ranavaya diagnosed pneumoconiosis and exertional angina pectoris. He concluded that Claimant's pneumoconiosis is caused by coal dust exposure. Dr. Ranavaya opined that Claimant has a mild pulmonary impairment caused by his pneumoconiosis. (DX 3). On May 15, 1995, Dr. Ranavaya submitted a supplemental report. He reviewed various X-rays and his August 17, 1994 examination report. Dr. Ranavaya reiterated that, in his opinion, Claimant has coal workers' pneumoconiosis. (DX 3).

Dr. Ranavaya examined the Claimant on October 10, 1992. (DX 2). Dr. Ranavaya noted 37 years of coal mine employment. Dr. Ranavaya noted that Claimant is a current smoker and began smoking in 1957. He listed Claimant's symptoms as sputum, dyspnea, cough, orthopnea and paroxysmal nocturnal dyspnea. He stated that Claimant becomes short of breath walking about one city block on level ground, climbing about 10 steps or lifting about 50 pounds. (DX 2).

Dr. Ranavaya diagnosed Mr. Elliott with pneumoconiosis. He concluded that Claimant's pneumoconiosis is caused by coal dust exposure for 37 years. Dr. Ranavaya determined that Mr. Elliott's pulmonary impairment is mild. Dr. Ranavaya stated that Claimant's impairment is caused by his pneumoconiosis. (DX 2).

Dr. Martin Fritzhand examined the Claimant on August 3, 1980. (DX 1). He noted that Claimant smoked 1 pack of cigarettes per day for 25 years. He noted that Claimant had a 4-5 year history of shortness of breath. Dr. Fritzhand diagnosed chronic obstructive pulmonary disease. He opined that Claimant's chronic obstructive pulmonary disease is caused by coal dust exposure. (DX 1).

III. Physician Office Notes

Mr. Elliott was treated by Dr. E. Kowalti at Logan General Hospital. (CX 1). Dr. Kowalti is Board-certified in internal medicine, pulmonary medicine, critical care medicine and sleep disorder medicine. (CX 14). Claimant began treatment with Dr. Kowalti in October 2003. He is currently treating with Dr. Kowalti. (CX 1). Dr. Kowalti concluded that Mr. Elliott has coal workers' pneumoconiosis and is totally disabled due to pneumoconiosis. Dr. Kowalti's first treatment notes are dated October 10, 2003. He stated that Claimant's CT scan showed bolus disease, barrel chest, and bilateral apical conglumare disease consistent with stage III black lung. He noted that Claimant has nocturnal dyspnea about five times a month and uses a Flovent inhaler. He listed his impression as Stage III pneumoconiosis, COPD/asthma, allergic rhinitis, and CAD. On December 3, 2003, Dr. Kowalti notes that Claimant's FEV1 is consistent with

"very severe obstructive ventilatory disease." He stated that Claimant also has air trapping. Dr. Kowalti listed his impression as: (1) pneumoconiosis stage III by chest X-ray, (2) very severe COPD/asthma, and (3) hypoxia. (CX 1).

On March 31, 2004, Dr. Kowalti lists his impression as COPD, pneumoconiosis and asthma. The same impression was listed on January 7, 2004. On January 7, 2004, Dr. Kowalti also noted less shortness of breath and chest clear. On May 26, 2004, Dr. Kowalti noted very severe COPD/pneumoconiosis. He listed that Claimant has shortness of breath and cough. (CX 1).

IV. Witness' Testimony

Mr. Elliott testified at the July 1, 2004 hearing. The Claimant stated that he is treated by Dr. Kowalti for his lung problems. He sees Dr. Kowalti "about every two months." The Claimant takes nebulizer breathing treatments three times a day. (TR 16). A mass was detected in 1992 in Claimant's chest. Claimant has a doctor check this mass once a year for any changes. Claimant also has yearly check-ups with his heart doctor. (TR 18).

Claimant testified that he stopped working at Buffalo Mining Company in 1992 due to his breathing problems. Claimant stated that he can walk about 50 feet on level ground before needing to take a break. He explained that lifting more than 20 pounds makes him "breathe hard." (TR 19).

Employer submitted Claimant's answers to interrogatories, dated December 10, 2001 and October 28, 2003, and supplemental interrogatory answers, dated May 28, 2004. Mr. Elliott stated that he has worked in the coal mines for 37 years. Claimant answered that he worked for Buffalo Mining Company as a mine foreman for twelve years. He described his foreman duties as supervisor of a crew of men, responsible for complete shift and fill-in vacant positions when necessary. Claimant noted that he had to lift and carry 50 to 75 pounds. (DX 27; EX 7; EX 23).

Claimant filed a state workers' compensation claim with the state of West Virginia in December 1986 and October 1992. He received 20% benefits for each claim. Claimant answered that he smoked for 30 plus years and is not currently smoking. He stated that the most he smoked was one pack of cigarettes per day. Mr. Elliott noted that he has been treated by Drs. Rosendo Dy and Emad Kowatli for breathing problems. Claimant stated that he cannot walk any distance, due to shortness of breath. (DX 27; EX 7; EX 23).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide*

Corp., 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987).

Since this is the claimant's fourth claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations. [28] Although the new regulations dispense with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), which was adopted by the United States Court of Appeals for the Fourth Circuit, in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). In *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. Section 725.309(d); *White v. New White Coal Co., Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. Section 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and

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[28] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of the July 13, 1994 claim, *i.e.*, pneumoconiosis and disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change.

The claimant's three prior applications for benefits were denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. (DX 1, 2, 3). Under the *Lisa Lee Mines* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

Since I have found below that the miner has established, by newly submitted medical evidence, that he has coal workers' pneumoconiosis and is totally disabled, he has met the duplicate claim threshold and the entire record will be examined to determine whether he is entitled to benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201. [29]

[29] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(*Emphasis added*).

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." [30] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. [31] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court

[30] The definition of pneumoconiosis, in 20 C.F.R. Section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[31] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), *i.e.*, the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis. Dr. Miller interpreted CT scans and X-rays of the Claimant. He noted evidence of complicated coal workers' pneumoconiosis. He also stated, however, that instead of complicated pneumoconiosis, the masses "could be" from previous granulomatous infection. No other equally-qualified reader found complicated coal workers' pneumoconiosis. As such, I accord Dr. Miller's possible complicated coal workers' pneumoconiosis finding little weight. Dr. Kowalti diagnosed very severe stage III pneumoconiosis. Dr. Kowalti's treatment records do not list any nodules one centimeter or greater. I find that Dr. Kowalti's treatment records do not support a finding of complicated coal workers' pneumoconiosis. Thus, I find that Claimant has not established complicated coal workers' pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (*Emphasis added*). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

The Claimant's most recent X-ray is dated April 10, 2004. Dr. Miller, a dually-qualified physician, interpreted this X-ray as positive for pneumoconiosis with a profusion of 1/2. A B-reader also interpreted the X-ray as positive. Dr. Scott, a dually-qualified physician, interpreted the X-ray as negative for pneumoconiosis. Dr. Scott noted nodules compatible with tuberculosis. In addition to finding evidence of pneumoconiosis, Dr. Miller also noted scarring possibly representing old tuberculosis. I thus find Dr. Miller's interpretation, which explains both a finding of pneumoconiosis and possible tuberculosis scarring, more persuasive than Dr. Scott's interpretation. Therefore, I find the April 10, 2004 X-ray positive for pneumoconiosis.

Two dually qualified physicians interpreted the July 1, 2002 X-ray, resulting in one positive reading and one negative reading. I find the July 1, 2002 X-ray in equipoise. Thus, it neither establishes nor precludes the existence of pneumoconiosis.

The March 27, 2002 X-ray was interpreted by three dually qualified physicians. Two physicians interpreted the X-ray as positive with a profusion of 1/1. Dr. Wiot interpreted the X-ray as negative. He noted evidence of emphysema and old granulomatous disease. Based on the physician qualifications and majority findings, I find the March 27, 2002 X-ray positive for pneumoconiosis.

Two dually qualified and one B-reader interpreted the January 30, 2002 X-ray. One dually qualified physician interpreted the X-ray as positive for pneumoconiosis. One dually qualified and one B-reader interpreted the X-ray as negative for pneumoconiosis, both noting evidence of emphysema. As such, I find the January 30, 2002 X-ray negative for pneumoconiosis.

Dr. Dameron, a Board-certified radiologist, was the only physician to interpret the December 12, 2001 X-ray. Dr. Dameron found "bilateral apical nodular densities which are probably underlying occupational lung disease." Dr. Dameron did not, however, provide an ILO classification of pneumoconiosis. Therefore, his interpretation cannot support a finding of pneumoconiosis. Thus, I find the December 12, 2001 X-ray negative for pneumoconiosis.

Two dually qualified physicians and one B-reader interpreted the October 23, 2001 X-ray. Dr. Wiot, a dually qualified physician, interpreted the X-ray as showing no evidence of pneumoconiosis. Dr. Wiot noted old granulomatous disease and emphysema. Dr. Miller, a dually qualified physician, and Dr. Ranavaya, a B-reader, interpreted the X-ray as positive with a profusion of 1/1. In addition to finding pneumoconiosis, Dr. Miller noted scarring that probably represents old tuberculosis and "COPD (em)." Thus, I find Dr. Miller's interpretation more persuasive than Dr. Wiot's interpretation. Furthermore, based on the two positive readings and one negative readings, I find the October 23, 2001 X-ray positive for pneumoconiosis.

In summary, for the X-ray evidence submitted in the current claim, I find the April 10, 2004, March 27, 2002, and October 23, 2001 X-rays positive for pneumoconiosis, the January 30, 2002 and December 12, 2001 X-rays negative for pneumoconiosis, and the July 1, 2002 X-ray in equipoise.

The evidence in the Claimant's three prior claims includes sixteen X-ray readings. Five of the sixteen readings were interpreted as positive for pneumoconiosis. The X-ray dates range from July 19, 1973 through April 28, 1995. Due to the fact that pneumoconiosis is a latent and progressive disease, I find that the X-ray evidence submitted in the current claim is more persuasive than the X-ray evidence submitted in the Claimant's three prior claims. The two most recent positive X-rays establish the existence of coal workers' pneumoconiosis.

As part of "other medical evidence," the parties submitted interpretations of three CT scans in the current claim.

The record contains four interpretations of the September 21, 2003 CT scan. Dr. Miller found evidence of complicated coal workers' pneumoconiosis. He also noted possible tuberculosis scarring. Dr. Cappiello found evidence of granulomatous disease, or coal workers' pneumoconiosis, or a combination of both. Dr. Cappiello also noted changes of COPD. He does not state whether the COPD is caused by coal dust exposure. Dr. Wiot did not find pneumoconiosis. He did find emphysema and old granulomatous disease. Dr. Shipley made the same findings as Dr. Wiot. The physicians reviewing the September 21, 2003 CT scan are equally qualified. Based on the conflicting views of granulomatous disease and pneumoconiosis, I find that the September 21, 2003 CT scan neither establishes nor precludes the existence of pneumoconiosis.

Drs. Miller, Cappiello, Wiot and Shipley also interpreted the July 13, 2002 X-ray. Dr. Miller found evidence of COPD, emphysema, pneumoconiosis and scarring suggestive of tuberculosis. Dr. Cappiello found nodules representing granulomas or pneumoconiosis or a combination of both. He also noted changes consistent with COPD. Dr. Wiot found evidence of emphysema and old granulomatous disease. Dr. Shipley made the same findings as Dr. Wiot. Based on the conflicting views of four equally qualified physicians, I find the July 13, 2002 CT scan neither establishes nor precludes the existence of pneumoconiosis.

Drs. Dameron, Miller, Cappiello, Fishman and Wheeler interpreted the December 12, 2001 CT scan. Drs. Dameron, Miller and Cappiello noted some evidence of occupational lung disease. Drs. Miller and Cappiello noted that the evidence may represent possible granulomatous disease. Drs. Fishman and Wheeler concluded that there is no evidence of pneumoconiosis. They both noted evidence of emphysema and tuberculosis. I find that the December 12, 2001 CT scan does not conclusively establish pneumoconiosis. It also does not conclusively establish that pneumoconiosis is not present.

Two interpretations of a May 12, 1994 CT scan were submitted in the Claimant's prior claims. Drs. Wheeler and Fishman found no evidence of pneumoconiosis. They did note scarring that could be due to tuberculosis. There are no positive interpretations of the May 12, 1994 CT scan in the record. Thus, I find the May 12, 1994 CT scan negative for pneumoconiosis. Because pneumoconiosis is a latent and progressive disease, I will give more weight to the CT scan evidence submitted in the current claim than the 1994 CT scan. As noted above, I find that the CT scan evidence submitted in the current claim neither establishes nor precludes the existence of pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it. [32] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of

[32] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Baker, Crisalli, Kowalti and Zaldivar above Dr. Ranavaya.

Dr. Baker performed the Claimant's most recent examination on April 10, 2004. Dr. Baker diagnosed Claimant with coal workers' pneumoconiosis. He concluded that Claimant's coal dust exposure caused his pneumoconiosis. Dr. Baker also diagnosed Claimant with COPD, chronic bronchitis, hypoxemia and ischemic heart disease. He explained that a combination of coal dust exposure and cigarette smoking caused the COPD, chronic bronchitis and hypoxemia. I find that Dr. Baker provided a reasoned opinion supported by objective evidence. Dr. Baker considered Claimant's complete history in determining the manner in which Claimant's smoking history and coal dust exposure caused his pulmonary impairment. As such, I find that Dr. Baker provided a reasoned and detailed opinion.

Dr. Crisalli examined the Claimant in 2002. He found no evidence of coal workers' pneumoconiosis. Dr. Crisalli diagnosed Claimant with COPD with components of emphysema and chronic bronchitis. Dr. Crisalli attributes Claimant's smoking history in causing his emphysema. He does not indicate the cause of Claimant's chronic bronchitis. He does, however, state that none of Claimant's pulmonary impairment is related to coal dust exposure. During a deposition, Dr. Crisalli noted that the reversibility found in Claimant's breathing test is evidence of asthma. Dr. Crisalli's deposition testimony is consistent with his report dated October 10, 2002. Dr. Crisalli diagnosed COPD, but stated that it is not due to coal dust exposure. Dr. Crisalli explained how he determined that Claimant's emphysema is due to smoking. He did not explain the cause of Claimant's chronic bronchitis. I find Dr. Baker's opinion more persuasive than Dr. Crisalli's opinion in that Dr. Baker explained the means by which Claimant's coal dust exposure and cigarette smoking caused portions of his pulmonary impairment.

Dr. Zaldivar also examined Mr. Elliott in 2002. Based on his examination of the claimant, Dr. Zaldivar diagnosed emphysema due to cigarette smoking. He concluded that the Claimant does not have any dust disease of the lungs. During a deposition, Dr. Zaldivar testified that Claimant has an airway obstruction that did not improve with bronchodilators. The results of the pulmonary function study taken during Dr. Crisalli's examination showed improvement after bronchodilators. Dr. Zaldivar explained that the difference may be attributed to contact with cigarette smoke prior to Dr. Crisalli's examination. Dr. Zaldivar testified that Claimant has emphysema and asthma. He based his asthma diagnosis solely on the reversibility found during Dr. Crisalli's breathing tests. Dr. Zaldivar stated that without a biopsy the issue of tuberculosis or histoplasmosis is unresolved. I find Dr. Baker's opinion diagnosing the Claimant with a coal dust and smoking related impairment more persuasive than Dr. Zaldivar's opinion due to the fact that Dr. Baker provided a diagnosis considering all the factors in Claimant's history which could affect his pulmonary impairment.

Dr. Ranavaya examined the Claimant in 2001. He also examined the Claimant in 1994 and 1992. Based on his examinations and the objective testing, Dr. Ranavaya diagnosed pneumoconiosis and coronary artery disease. He determined that Claimant's pneumoconiosis is caused by coal dust exposure. Dr. Ranavaya diagnosed pneumoconiosis at all three of his examinations of the Claimant. I find that Dr. Ranavaya's opinion is reasoned and supported by the objective evidence.

In summary, I find the opinion of Dr. Baker more persuasive than the opinions of Drs. Crisalli and Zaldivar. I find that Dr. Ranavaya provided a reasoned opinion.

In Claimant's prior claims for benefits, Drs. Zaldivar, Rasmussen, Ranavaya and Fitzhand submitted reports. Dr. Zaldivar diagnosed emphysema. He did not find a coal dust related impairment. Dr. Rasmussen diagnosed coal workers' pneumoconiosis. He also stated that smoking caused some of claimant's respiratory impairment. Dr. Ranavaya diagnosed pneumoconiosis and exertional angina pectoris. Dr. Fitzhand diagnosed chronic obstructive pulmonary disease caused by coal dust exposure. Thus, three of the four doctors diagnosed claimant with a coal dust related respiratory impairment. Although I find that the four doctors provided reasoned medical opinions, due to the latent and progressive nature of coal workers' pneumoconiosis, I give more weight to the medical opinions submitted in the current claim.

While the courts and the Board earlier recognized that there may be a practical distinction between a physician who merely examines a miner and one who is one of his "treating" physicians, that preference has largely been obviated, except in the Third Circuit. [33] In *Black and Decker Disability Plan v. Nord,* Case No. 02-469, ___ U.S. ___, ___ S.Ct. ___ (May 27, 2003), the Court held ERISA plan administrators (Courts) need not give special deference to the

[33] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994). *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for Judge to accord greater weight to treating physician over non-examining doctors). *Lango v. Director, OWCP*, 104 F.3d 573 (3rd Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co*., 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians), "a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)." *But see, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin,* 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.3d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989).
Consolidation Coal Co. v. Director, OWCP [Held], ___ F.3d ___, Case No. 99-2507 (4th Cir. Dec. 20, 2000)(with Dissent). Improper to accord greater weight to the opinion of treating physician because he had treated and examined claimant each year over the past ten years. In *Grizzle v. Pickland Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993), we clearly stated we had not fashioned any presumption or requirement that the treating physicians' opinions be given greater weight. While the treating physician's opinion here may have been entitled to "special consideration", it was not entitled to the greater weight accorded. In *Eastover Mining Co. v. Director, OWCP [Williams]*, ___ F.3d ___, No. 01-4064 (6th Cir. July 31, 2003), the Court made clear its view that no deference is given to treating physicians merely because of their status as the same. It pointed out, citing *Black & Decker Disability Plan v. Nord*, 123 S.Ct. at 1969, 1971, the Supreme Court itself has "disapproved of the 'treating physician rule' with language that criticizes the principle itself, rather than its operation in an ERISA context."

opinion of a treating physician. Dr. Kowalti is Mr. Elliott's treating physician. As such, his opinion must be considered under the criteria of section 718.104(d). [34]

Dr. Kowalti is currently treating Claimant for his pulmonary problems. Claimant's treatment with Dr. Kowalti began in October 2003. Dr. Kowalti is Board-certified in internal medicine and pulmonary medicine. Dr. Kowalti diagnosed Claimant with coal workers' pneumoconiosis, very severe COPD/asthma, hypoxia and coronary artery disease. His most recent treatment, dated May 26, 2004, notes very severe COPD/pneumoconiosis. His treatment consistently notes coal workers' pneumoconiosis. I find that Dr. Kowalti's records are reasoned and detailed. The frequent visits, the consistent findings and support by objective evidence provide a persuasive diagnosis. There has not been an extensive duration of the physician/patient relationship. The treatment records provide less than one year of treatment. I do, however, accord special consideration to Dr. Kowalti's opinion given his Board-certifications and the subject of his treatment of the Claimant. Dr. Kowalti is not merely Claimant's family physician. Dr. Kowalti's treatment of the Claimant is solely for claimant's pulmonary impairment.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

Claimant filed for and received benefits from the West Virginia State Worker's Compensation Fund. Claimant filed two occupational pneumoconiosis claims and received 20% in each claim for a total of 40%. (DX 8).

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[34] § 718.104(d) Treating Physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication office shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officers' decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

A general disability determination by a state or other agency is not binding on the Department of Labor with regard to a claim field under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder. [35] *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a "15% pulmonary functional impairment" is relevant to disability but not binding). *McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988). Thus, I give the state determination some weight as to the existence of pneumoconiosis.

Although the CT scan evidence is in equipoise, the positive CT scan readings support my finding of coal workers' pneumoconiosis based on X-ray evidence. Dr. Baker diagnosed Claimant with chronic obstructive pulmonary disease caused by coal dust exposure and cigarette smoking. Dr. Baker's diagnosis of COPD equates to a finding of legal coal workers' pneumoconiosis. Furthermore, Dr. Baker's COPD etiology is more consistent with Claimant's history of coal mine employment and smoking history. As noted above, Dr. Kowalti is highly qualified and treats Mr. Elliott on a regular basis for his respiratory impairment. As such, I find his conclusions of Claimant's impairment compelling evidence in determining pneumoconiosis. Therefore, after weighing the X-rays, CT scans, state disability determination, and physician opinions, I find the claimant has met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Nor does the record contain contrary evidence that establishes the claimant's pneumoconiosis arose out of alternative causes.

[35] See § 718.206 "Effect of findings y persons or agencies." (65 Fed. Reg. 80050, Dec. 20, 2000) (Effective Jan. 19, 2001). If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). [36] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993).

Four pre-bronchodilator studies and three post-bronchodilator studies were submitted in the claimant's current claim for benefits. All of these pulmonary function studies produced qualifying results.

The evidence in the Claimant's three prior claims includes six pre-bronchodilator studies and five post-bronchodilator studies. Seven of the studies produced qualifying results. Four of the studies did not show total disability.

I accord the most weight to the studies submitted in the current claim. The dates for these studies range from October 23, 2001 through April 10, 2004. As such, I find the Claimant has proven total disability based on pulmonary function studies.

[36] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

Arterial blood gas studies were performed on October 23, 2001, January 30, 2002, July 1, 2002 and April 10, 2004. None of these studies produced qualifying results. Additionally, there were four arterial blood gas studies submitted in Claimant's three prior claims for benefits. None of these studies produced qualifying results. Thus, I find the Claimant did not prove total disability based on arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As noted above, the current claim includes medical reports by Drs. Baker, Crisalli, Zaldivar, Ranavaya and Kowalti. These doctors agree that Claimant has a totally disabling respiratory impairment which would prevent him from performing his previous coal mine employment.

Mr. Elliott's prior claims for benefits include medical reports by Drs. Fitzhand, Rasmussen, Ranavaya and Zaldivar. Dr. Zaldivar opined that, from a respiratory standpoint, Mr. Elliott could perform supervisory work, but not heavy labor. Dr. Rasmussen concluded that Claimant's respiratory impairment would prevent him performing his previous coal mine employment. Dr. Ranavaya found a mild pulmonary impairment. Dr. Fitzhand did not state any conclusions regarding the extent of claimant's impairment. The arterial blood gas study and pulmonary function study performed during Dr. Fitzhand's examination were non-qualifying.

I accord the most weight to Claimant's most recent medical reports. As such, I find the Claimant has proven total disability based on physician opinions.

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to walk short distances and do heavy lifting, I find he is incapable of performing his prior coal mine employment.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street,* 42 f.3D 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP, [Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court had "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments." Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability [37]

The revised regulations, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000). [38]

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability. [39] *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

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[37] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. __, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

[38] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[39] *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L..R 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or 'substantial' cause." *Id.*

It is proper for judge to accord less weight to physicians' opinions which found that pneumoconiosis did not contribute to the miner's disability on the grounds that the physicians did not diagnose pneumoconiosis. *Osborne v. Westmoreland Coal Co.*, ___ B.L.R. ___, BRB No. 96-1523 BLA (April 30, 1998).

Where an Administrative Law Judge determines that a miner suffers from pneumoconiosis, a medical opinion finding the miner does not suffer from the disease "can carry little weight" in assessing the etiology of the miner's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109, 116 (4th Cir. 1995). [40] *Grigg v. Director, OWCP*, 28 F.3d 416, 419 (4th Cir. 1994). If a physician finds no respiratory or pulmonary impairment based on an erroneous diagnosis that the miner does not suffer from pneumoconiosis, her opinion is "not worth of much, if any, weight." *Citing Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993). [41]

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. [42] However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990). [43]

Dr. Baker determined that Claimant has a totally disabling respiratory impairment. He attributed Claimant's impairment to both smoking and coal dust exposure. Dr. Ranavaya

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[40] The Court noted that the Administrative Law Judge may credit such an opinion if there are "specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon her disagreement with the Administrative Law Judge's findings as to either or both of the predicates [pneumoconiosis and total disability] in the causal chain." *Toler*, 43 F.3d at 116. I find no such "specific or persuasive reasons" to conclude so in this case. See also, *Scott v. Mason Coal Co.*, 289 F.3d 263, 22 B.L.R. 2-374 (4th Cir. May 2, 2002)(Upholding *Toler*).

[41] *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994) *cites Skukan v. Consolidation Coal Co.*, 993 F.2d 1228, 1233, 17 B.L.R. 2-97, 2-104 (6th Cir. 1993) for the proposition that the "better way" for a judge to proceed in evaluating whether the evidence establishes a miner's total disability is due to pneumoconiosis "is to treat as less significant those physician's opinions about causation when they find no pneumoconiosis."

[42] *Sewell Coal Co. v. Director, OWCP [O'Dell]* (Unpublished), 22 B.L.R. 2-213, No. 00-2253 (4th Cir. July 26, 2001)(Unpublished). "…the mere documentation of a smoking history on the official OWCP form or elsewhere, without more, cannot reasonably imply that an examining physician has 'addressed the possibility that cigarette smoking caused the claimant's disability." *Malcomb v. Island Creek Coal Co.*, 15 F.3d 364 at 371 (4th Cir. 1994).

[43] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claim…in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

determined that Claimant's pneumoconiosis caused his pulmonary impairment "to a major extent." Dr. Kowalti concluded that Claimant is totally disabled due to pneumoconiosis. Drs. Crisalli and Zaldivar did not diagnosis pneumoconiosis. They determined that Claimant is totally disabled due to smoking related emphysema.

Drs. Zaldivar and Rasmussen submitted reports in Claimant's third claim for benefits concluding that Claimant's pulmonary impairment would prevent him from performing his prior coal mine employment. Dr. Zaldivar diagnosed claimant with emphysema. Dr. Rasmussen diagnosed coal workers' pneumoconiosis. He opined that smoking and pneumoconiosis caused Claimant's pulmonary impairment. Dr. Rasmussen stated that the pneumoconiosis "must be considered at least a major contributing factor" to Claimant's pulmonary impairment.

I accord the most weight to Claimant's most recent evidence. I accord little weight to the opinions of Drs. Crisalli and Zaldivar regarding the etiology of Mr. Elliott's total disability due to the fact that they did not diagnose coal workers' pneumoconiosis and did not provide specific and persuasive reasons for crediting their opinions. As such, I find that the evidence establishes that pneumoconiosis is a contributing cause of Claimant's total disability.

F. Date of Entitlement[44]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis [45] 20 C.F.R. § 725.503. Because no specific onset date of disability is evident from the record, benefits will begin on the first day of the month in which he filed this claim. 20 C.F.R. § 725.503(b). [46] The Claimant filed his claim on August 15, 2001.

ATTORNEY FEES

An application by the claimant's attorney for approval of a fee has been received; therefore no award of attorney's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365-725.366. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging a fee in the absence of an approved application.

[44] 20 C.F.R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[45] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1310 (1984).

[46] *Dempsey v. Sewell Coal Co. & Director, OWCP,* __ B.L.R. __, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). ALJ merely concluded, in general terms, that the evidence did not establish an exact date of onset of total disability. This was error. In determining the onset date, the Administrative Law Judge must consider all relevant evidence of record and assess the credibility of that evidence. *Lykins, supra* at 1-183.

CONCLUSIONS

In conclusion, the claimant has established a change in an applicable element of entitlement upon which the order denying the prior claim became final, because he is now disabled due to pneumoconiosis. The claimant has pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis arose out of his coal mine employment. The claimant is totally disabled. His total disability is due to pneumoconiosis. He is therefore entitled to benefits.

ORDER[47]

It is ordered that the claim of Earl Elliott for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the employer, Buffalo Mining Company, shall pay [48] to the claimant all benefits to which he is entitled under the Act commencing August 1, 2001. [49]

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

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[47] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[48] 20 C.F.R. § 725.502(a)(1)(65 Fed. Reg. 80085, Dec. 20, 2000) provides "Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated."

[49] 20 C.F.R. § 725.530 (within 30 days of this order). In any case in which the fund has paid benefits on behalf of an operator or employer, the latter shall simultaneously with the first payment of benefits to the beneficiary, reimburse the fund (with interest) for the full amount of all such payments. 20 C.F.R. § 725.602(a).

If an employer does not pay benefits after the Director's initial determination of eligibility, it may be ordered to pay the beneficiary simple interest on all past due benefits (and attorney's fee) at a rate according to the Internal Revenue Code § 6621. 20 C.F.R. §§ 725.608(a) and 725.608(c).

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, *i.e.*, at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of**

[50] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.